

**Introduced by Senator Hernandez
(Coauthor: Senator Monning)**

December 5, 2014

An act to amend Section 1367.005 of the Health and Safety Code, and to amend Section 10112.27 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 43, as introduced, Hernandez. Health care coverage: essential health benefits.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires a health insurance issuer that offers coverage in the small group or individual market to ensure that the coverage includes the essential health benefits package, as defined. PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires

an individual or small group health care service plan contract or individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2015, to cover essential health benefits, defined to include the health benefits covered by particular benchmark plans. Existing law specifies that these provisions do not apply to specified plans, including grandfathered plans. Existing law authorizes the Department of Managed Health Care and the Department of Insurance to adopt emergency regulations implementing these provisions until March 1, 2016.

This bill would authorize the Department of Managed Health Care and the Department of Insurance to adopt emergency regulations implementing amendments made to the above-described provisions during the 2015–16 Regular Session until July 1, 2018.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1367.005 of the Health and Safety Code,
2 as amended by Section 7 of Chapter 572 of the Statutes of 2014,
3 is amended to read:
4 1367.005. (a) An individual or small group health care service
5 plan contract issued, amended, or renewed on or after January 1,
6 2014, shall, at a minimum, include coverage for essential health
7 benefits pursuant to PPACA and as outlined in this section. For
8 purposes of this section, “essential health benefits” means all of
9 the following:
10 (1) Health benefits within the categories identified in Section
11 1302(b) of PPACA: ambulatory patient services, emergency
12 services, hospitalization, maternity and newborn care, mental health
13 and substance use disorder services, including behavioral health
14 treatment, prescription drugs, rehabilitative and habilitative services
15 and devices, laboratory services, preventive and wellness services
16 and chronic disease management, and pediatric services, including
17 oral and vision care.
18 (2) (A) The health benefits covered by the Kaiser Foundation
19 Health Plan Small Group HMO 30 plan (federal health product
20 identification number 40513CA035) as this plan was offered during
21 the first quarter of 2012, as follows, regardless of whether the

benefits are specifically referenced in the evidence of coverage or plan contract for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 and in Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under this chapter, to the extent required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under this chapter.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements

1 for health benefits under this chapter that were enacted prior to
2 December 31, 2011, the requirements of this chapter shall be
3 controlling, except as otherwise specified in this section.

4 (C) Notwithstanding subparagraph (B) or any other provision
5 of this section, the home health services benefits covered under
6 the plan identified in subparagraph (A) shall be deemed to not be
7 in conflict with this chapter.

8 (D) For purposes of this section, the Paul Wellstone and Pete
9 Domenici Mental Health Parity and Addiction Equity Act of 2008
10 (Public Law 110-343) shall apply to a contract subject to this
11 section. Coverage of mental health and substance use disorder
12 services pursuant to this paragraph, along with any scope and
13 duration limits imposed on the benefits, shall be in compliance
14 with the Paul Wellstone and Pete Domenici Mental Health Parity
15 and Addiction Equity Act of 2008 (Public Law 110-343), and all
16 rules, regulations, or guidance issued pursuant to Section 2726 of
17 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

18 (3) With respect to habilitative services, in addition to any
19 habilitative services identified in paragraph (2), coverage shall
20 also be provided as required by federal rules, regulations, and
21 guidance issued pursuant to Section 1302(b) of PPACA.
22 Habilitative services shall be covered under the same terms and
23 conditions applied to rehabilitative services under the plan contract.

24 (4) With respect to pediatric vision care, the same health benefits
25 for pediatric vision care covered under the Federal Employees
26 Dental and Vision Insurance Program vision plan with the largest
27 national enrollment as of the first quarter of 2012. The pediatric
28 vision care benefits covered pursuant to this paragraph shall be in
29 addition to, and shall not replace, any vision services covered under
30 the plan identified in paragraph (2).

31 (5) With respect to pediatric oral care, the same health benefits
32 for pediatric oral care covered under the dental plan available to
33 subscribers of the Healthy Families Program in 2011–12, including
34 the provision of medically necessary orthodontic care provided
35 pursuant to the federal Children’s Health Insurance Program
36 Reauthorization Act of 2009. The pediatric oral care benefits
37 covered pursuant to this paragraph shall be in addition to, and shall
38 not replace, any dental or orthodontic services covered under the
39 plan identified in paragraph (2).

1 (b) Treatment limitations imposed on health benefits described
2 in this section shall be no greater than the treatment limitations
3 imposed by the corresponding plans identified in subdivision (a),
4 subject to the requirements set forth in paragraph (2) of subdivision
5 (a).

6 (c) Except as provided in subdivision (d), nothing in this section
7 shall be construed to permit a health care service plan to make
8 substitutions for the benefits required to be covered under this
9 section, regardless of whether those substitutions are actuarially
10 equivalent.

11 (d) To the extent permitted under Section 1302 of PPACA and
12 any rules, regulations, or guidance issued pursuant to that section,
13 and to the extent that substitution would not create an obligation
14 for the state to defray costs for any individual, a plan may substitute
15 its prescription drug formulary for the formulary provided under
16 the plan identified in subdivision (a) as long as the coverage for
17 prescription drugs complies with the sections referenced in clauses
18 (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision
19 (a) that apply to prescription drugs.

20 (e) No health care service plan, or its agent, solicitor, or
21 representative, shall issue, deliver, renew, offer, market, represent,
22 or sell any product, contract, or discount arrangement as compliant
23 with the essential health benefits requirement in federal law, unless
24 it meets all of the requirements of this section.

25 (f) This section shall apply regardless of whether the plan
26 contract is offered inside or outside the California Health Benefit
27 Exchange created by Section 100500 of the Government Code.

28 (g) Nothing in this section shall be construed to exempt a plan
29 or a plan contract from meeting other applicable requirements of
30 law.

31 (h) This section shall not be construed to prohibit a plan contract
32 from covering additional benefits, including, but not limited to,
33 spiritual care services that are tax deductible under Section 213 of
34 the Internal Revenue Code.

35 (i) Subdivision (a) shall not apply to any of the following:

36 (1) A specialized health care service plan contract.

37 (2) A Medicare supplement plan.

38 (3) A plan contract that qualifies as a grandfathered health plan
39 under Section 1251 of PPACA or any rules, regulations, or
40 guidance issued pursuant to that section.

1 (j) Nothing in this section shall be implemented in a manner
2 that conflicts with a requirement of PPACA.

3 (k) This section shall be implemented only to the extent essential
4 health benefits are required pursuant to PPACA.

5 (l) An essential health benefit is required to be provided under
6 this section only to the extent that federal law does not require the
7 state to defray the costs of the benefit.

8 (m) Nothing in this section shall obligate the state to incur costs
9 for the coverage of benefits that are not essential health benefits
10 as defined in this section.

11 (n) A plan is not required to cover, under this section, changes
12 to health benefits that are the result of statutes enacted on or after
13 December 31, 2011.

14 (o) (1) The department may adopt emergency regulations
15 implementing this section. The department may, on a one-time
16 basis, readopt any emergency regulation authorized by this section
17 that is the same as, or substantially equivalent to, an emergency
18 regulation previously adopted under this section.

19 (2) The initial adoption of emergency regulations implementing
20 this section and the readoption of emergency regulations authorized
21 by this subdivision shall be deemed an emergency and necessary
22 for the immediate preservation of the public peace, health, safety,
23 or general welfare. The initial emergency regulations and the
24 readoption of emergency regulations authorized by this section
25 shall be submitted to the Office of Administrative Law for filing
26 with the Secretary of State and each shall remain in effect for no
27 more than 180 days, by which time final regulations may be
28 adopted.

29 (3) *The initial adoption of emergency regulations implementing*
30 *amendments to this section made during the 2015–16 Regular*
31 *Session and the readoption of emergency regulations authorized*
32 *by this subdivision shall be deemed an emergency and necessary*
33 *for the immediate preservation of the public peace, health, safety,*
34 *or general welfare. The initial emergency regulations and the*
35 *readoption of emergency regulations authorized by this section*
36 *shall be submitted to the Office of Administrative Law for filing*
37 *with the Secretary of State and each shall remain in effect for no*
38 *more than 180 days, by which time final regulations may be*
39 *adopted.*

40 (3)

(4) The director shall consult with the Insurance Commissioner to ensure consistency and uniformity in the development of regulations under this subdivision.

~~(4)~~

(5) This subdivision shall become inoperative on ~~March 1, 2016.~~
July 1, 2018.

(p) For purposes of this section, the following definitions shall apply:

(1) “Habilitative services” means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(2) (A) “Health benefits,” unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) “Health benefits” does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) “Small group health care service plan contract” means a group health care service plan contract issued to a small employer, as defined in Section 1357.500.

SEC. 2. Section 10112.27 of the Insurance Code, as amended by Section 14 of Chapter 572 of the Statutes of 2014, is amended to read:

1 10112.27. (a) An individual or small group health insurance
2 policy issued, amended, or renewed on or after January 1, 2014,
3 shall, at a minimum, include coverage for essential health benefits
4 pursuant to PPACA and as outlined in this section. This section
5 shall exclusively govern what benefits a health insurer must cover
6 as essential health benefits. For purposes of this section, “essential
7 health benefits” means all of the following:

8 (1) Health benefits within the categories identified in Section
9 1302(b) of PPACA: ambulatory patient services, emergency
10 services, hospitalization, maternity and newborn care, mental health
11 and substance use disorder services, including behavioral health
12 treatment, prescription drugs, rehabilitative and habilitative services
13 and devices, laboratory services, preventive and wellness services
14 and chronic disease management, and pediatric services, including
15 oral and vision care.

16 (2) (A) The health benefits covered by the Kaiser Foundation
17 Health Plan Small Group HMO 30 plan (federal health product
18 identification number 40513CA035) as this plan was offered during
19 the first quarter of 2012, as follows, regardless of whether the
20 benefits are specifically referenced in the plan contract or evidence
21 of coverage for that plan:

22 (i) Medically necessary basic health care services, as defined
23 in subdivision (b) of Section 1345 of the Health and Safety Code
24 and in Section 1300.67 of Title 28 of the California Code of
25 Regulations.

26 (ii) The health benefits mandated to be covered by the plan
27 pursuant to statutes enacted before December 31, 2011, as
28 described in the following sections of the Health and Safety Code:
29 Sections 1367.002, 1367.06, and 1367.35 (preventive services for
30 children); Section 1367.25 (prescription drug coverage for
31 contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46
32 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha
33 fetoprotein testing); Section 1367.6 (breast cancer screening);
34 Section 1367.61 (prosthetics for laryngectomy); Section 1367.62
35 (maternity hospital stay); Section 1367.63 (reconstructive surgery);
36 Section 1367.635 (mastectomies); Section 1367.64 (prostate
37 cancer); Section 1367.65 (mammography); Section 1367.66
38 (cervical cancer); Section 1367.665 (cancer screening tests);
39 Section 1367.67 (osteoporosis); Section 1367.68 (surgical
40 procedures for jaw bones); Section 1367.71 (anesthesia for dental);

1 Section 1367.9 (conditions attributable to diethylstilbestrol);
2 Section 1368.2 (hospice care); Section 1370.6 (cancer clinical
3 trials); Section 1371.5 (emergency response ambulance or
4 ambulance transport services); subdivision (b) of Section 1373
5 (sterilization operations or procedures); Section 1373.4 (inpatient
6 hospital and ambulatory maternity); Section 1374.56
7 (phenylketonuria); Section 1374.17 (organ transplants for HIV);
8 Section 1374.72 (mental health parity); and Section 1374.73
9 (autism/behavioral health treatment).

10 (iii) Any other benefits mandated to be covered by the plan
11 pursuant to statutes enacted before December 31, 2011, as
12 described in those statutes.

13 (iv) The health benefits covered by the plan that are not
14 otherwise required to be covered under Chapter 2.2 (commencing
15 with Section 1340) of Division 2 of the Health and Safety Code,
16 to the extent otherwise required pursuant to Sections 1367.18,
17 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
18 and Safety Code, and Section 1300.67.24 of Title 28 of the
19 California Code of Regulations.

20 (v) Any other health benefits covered by the plan that are not
21 otherwise required to be covered under Chapter 2.2 (commencing
22 with Section 1340) of Division 2 of the Health and Safety Code.

23 (B) Where there are any conflicts or omissions in the plan
24 identified in subparagraph (A) as compared with the requirements
25 for health benefits under Chapter 2.2 (commencing with Section
26 1340) of Division 2 of the Health and Safety Code that were
27 enacted prior to December 31, 2011, the requirements of Chapter
28 2.2 (commencing with Section 1340) of Division 2 of the Health
29 and Safety Code shall be controlling, except as otherwise specified
30 in this section.

31 (C) Notwithstanding subparagraph (B) or any other provision
32 of this section, the home health services benefits covered under
33 the plan identified in subparagraph (A) shall be deemed to not be
34 in conflict with Chapter 2.2 (commencing with Section 1340) of
35 Division 2 of the Health and Safety Code.

36 (D) For purposes of this section, the Paul Wellstone and Pete
37 Domenici Mental Health Parity and Addiction Equity Act of 2008
38 (Public Law 110-343) shall apply to a policy subject to this section.
39 Coverage of mental health and substance use disorder services
40 pursuant to this paragraph, along with any scope and duration

limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) With respect to habilitative services, in addition to any habilitative services identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children’s Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), nothing in this section shall be construed to permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may

1 substitute its prescription drug formulary for the formulary
2 provided under the plan identified in subdivision (a) as long as the
3 coverage for prescription drugs complies with the sections
4 referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph
5 (2) of subdivision (a) that apply to prescription drugs.

6 (e) No health insurer, or its agent, producer, or representative,
7 shall issue, deliver, renew, offer, market, represent, or sell any
8 product, policy, or discount arrangement as compliant with the
9 essential health benefits requirement in federal law, unless it meets
10 all of the requirements of this section. This subdivision shall be
11 enforced in the same manner as Section 790.03, including through
12 the means specified in Sections 790.035 and 790.05.

13 (f) This section shall apply regardless of whether the policy is
14 offered inside or outside the California Health Benefit Exchange
15 created by Section 100500 of the Government Code.

16 (g) Nothing in this section shall be construed to exempt a health
17 insurer or a health insurance policy from meeting other applicable
18 requirements of law.

19 (h) This section shall not be construed to prohibit a policy from
20 covering additional benefits, including, but not limited to, spiritual
21 care services that are tax deductible under Section 213 of the
22 Internal Revenue Code.

23 (i) Subdivision (a) shall not apply to any of the following:

24 (1) A policy that provides excepted benefits as described in
25 Sections 2722 and 2791 of the federal Public Health Service Act
26 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

27 (2) A policy that qualifies as a grandfathered health plan under
28 Section 1251 of PPACA or any binding rules, regulation, or
29 guidance issued pursuant to that section.

30 (j) Nothing in this section shall be implemented in a manner
31 that conflicts with a requirement of PPACA.

32 (k) This section shall be implemented only to the extent essential
33 health benefits are required pursuant to PPACA.

34 (l) An essential health benefit is required to be provided under
35 this section only to the extent that federal law does not require the
36 state to defray the costs of the benefit.

37 (m) Nothing in this section shall obligate the state to incur costs
38 for the coverage of benefits that are not essential health benefits
39 as defined in this section.

(n) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(o) (1) The commissioner may adopt emergency regulations implementing this section. The commissioner may, on a one-time basis, readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing amendments to this section made during the 2015–16 Regular Session and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

~~(3)~~

(4) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

~~(4)~~

(5) This subdivision shall become inoperative on ~~March 1, 2016~~.
July 1, 2018.

(p) Nothing in this section shall impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required

1 to comply with provisions of this code, including this section, and
2 as otherwise applicable to all health insurance policies offered to
3 individuals and small groups.

4 (q) For purposes of this section, the following definitions shall
5 apply:

6 (1) “Habilitative services” means medically necessary health
7 care services and health care devices that assist an individual in
8 partially or fully acquiring or improving skills and functioning and
9 that are necessary to address a health condition, to the maximum
10 extent practical. These services address the skills and abilities
11 needed for functioning in interaction with an individual’s
12 environment. Examples of health care services that are not
13 habilitative services include, but are not limited to, respite care,
14 day care, recreational care, residential treatment, social services,
15 custodial care, or education services of any kind, including, but
16 not limited to, vocational training. Habilitative services shall be
17 covered under the same terms and conditions applied to
18 rehabilitative services under the policy.

19 (2) (A) “Health benefits,” unless otherwise required to be
20 defined pursuant to federal rules, regulations, or guidance issued
21 pursuant to Section 1302(b) of PPACA, means health care items
22 or services for the diagnosis, cure, mitigation, treatment, or
23 prevention of illness, injury, disease, or a health condition,
24 including a behavioral health condition.

25 (B) “Health benefits” does not mean any cost-sharing
26 requirements such as copayments, coinsurance, or deductibles.

27 (3) “PPACA” means the federal Patient Protection and
28 Affordable Care Act (Public Law 111-148), as amended by the
29 federal Health Care and Education Reconciliation Act of 2010
30 (Public Law 111-152), and any rules, regulations, or guidance
31 issued thereunder.

32 (4) “Small group health insurance policy” means a group health
33 insurance policy issued to a small employer, as defined in Section
34 10753.